*Maryland HealthChoice*
*Section 1115 Waiver Demonstration*

# Application Package for Evidence-Based Home Visiting Services for High Risk Pregnant Women & Children up to Age 2 (HVS) Pilot Program

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**Overview**

Thank you for your interest in applying for federal matching funds available for the Medicaid Community Health Pilots through a service expansion initiative of the State of Maryland's Medicaid §1115 HealthChoice Waiver Program. The Department of Health and Mental Hygiene (DHMH) is facilitating receipt of federal matching funds for the following Pilot program: Evidence-Based Home Visiting Services (HVS) for High Risk Pregnant Women and Children Up to Age Two (2) Years.

The HVS Pilot application must be completed by a lead local government entity (Lead Entity) with the ability to fund fifty percent (50%) of Pilot costs with local dollars through an intergovernmental transfer (IGT) process. Lead Entities will also be required to provide leadership and coordinate with key community partners to deliver the programs.

The HVS Pilot is effective from July 1, 2017 through December 31, 2021. Up to $2.7 in matching federal funds are available annually, and when combined with the local non-federal share, HVS Pilot expenditures may total up to $5.4 million annually. Applicants' funding assumptions will be derived from a "per home visit services rate" that shall be developed and proposed by the Lead Entity. Details of the program's parameters may be found in the Special Terms and Conditions (STC) 29 – Attachment D: Evidence-Based Home Visiting Services Pilot Protocol, Approved: April 27, 2017 (STC 29: Attachment D) (Appendix B).

DHMH shall review, approve, and make award payments for HVS Pilots in accordance with the requirements in the approved Waiver, using the Application Selection Criteria outlined in Appendix C. Pilot award payments shall support delivery of evidence-based home visiting services by licensed practitioners or certified home visitors to improve health outcomes and whole person care for high risk pregnant women and children up to two (2) years old. Payments are for services not otherwise covered or directly reimbursed by Maryland Medicaid.

The HVS Pilot program is aligned with two evidence-based models focused on the health of pregnant women:

a. Nurse Family Partnership (NFP): The NFP model is designed to reinforce maternal behaviors that encourage a positive parent-child relationship and maternal, child, and family accomplishments. The HealthChoice section 1115 demonstration NFP pilot program will adhere to the NFP national program standards and service will be suspended once the child reaches two (2) years old.
b. Healthy Families America (HFA): The HFA model targets parents facing issues such as single parenthood, low income, childhood history of abuse, substance use disorder (SUD), mental health issues, or domestic violence.

The HVS Pilot application timeline is below:

| | |
|---|---|
| 1. HVS Pilot Request for Application (RFA) Published by DHMH; FAQs Released | June 7, 2017 |
| 2. HVS Pilot Application Process Webinar and Review of FAQs | June 21, 2017, 1:30pm-3pm |
| 3. Pilot Applications Due to DHMH | July 21, 2017 |
| 4. Calls with Applicants (Clarification & Application Modification Discussions) | July 24-27, 2017 |

| | |
|---|---|
| 5. HVS Pilot Awards Notifications (Expected Date, Pending Final CMS Approval) | August 28, 2017 |
| 6. HVS Pilots Begin Operations (Based Upon Approved Pilot Implementation) Plans) | Sept/Oct 2017 |

**Eligibility for Funding**
DHMH will accept applications for the HVS Pilots from Local Health Departments or other local government entities, such as a local management board, who meet Lead Entity requirements (see section 1.1). Applicants must serve as the Lead Entity throughout the HVS Pilot and must be permitted to participate in the financing of the non-federal portion of medical assistance expenditures.

**Local Government Funding Requirements**
Each Lead Entity must provide the non-federal share of funds through an intergovernmental transfer (IGT). No State Medicaid funding match is available for the HVS Pilots. Lead Entities shall certify that the funds transferred qualify for federal financial participation pursuant to 42 C.F.R part 433 subpart B and are not derived from impermissible sources such as recycled Medicaid payments, federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. The Centers for Medicare & Medicaid Services (CMS) reserve the right to review the sources of the non-federal share of the funding for the demonstration at any time. Sources of non-federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible intergovernmental transfers from providers, or federal funds received from federal programs other than Medicaid (unless expressly authorized by federal statutes to be used for claiming purposes, and the federal Medicaid funding is credited to the other federal funding source).

Pilot payments are not considered patient care revenue. The payments do not offset payment amounts otherwise payable by the local entity for beneficiaries, or supplant provider payments from the local entities.

The Lead Entities will make the intergovernmental transfer of funds to DHMH in the amount specified. Upon receipt of the Lead Entity's intergovernmental transfer, DHMH will draw the federal funding and transfer back to the Lead Entity the combined non-federal funds and its corresponding federal match through a payment. The Lead Entity will be responsible for the subsequent disbursement of funds to contracted Participating Entities, as specified in STC 29: Attachment D (Appendix B).

Local funds that are eligible for federal match include local (city, county, town) tax revenues, private philanthropic grants, and non-profit funding not derived from Federal government funds.

**General Instructions**
In order to apply, the organization that will serve as the Lead Entity of the HVS Pilot Program must complete, sign and submit this application by the due date. Prior to completing this application, it is strongly suggested that applicants carefully review the documents that govern the Medicaid Program §1115 HealthChoice Waiver, available on the Maryland Department of Health and Mental Hygiene (DHMH) website https://mmcp.health.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx, including:

- CMS Special Terms & Conditions : Attachment D: Evidence-Based Home Visiting Services Pilot

Protocols
- Evidence-Based Home Visiting Model Criteria & Requirements
    - Nurse Family Partnership, http://www.nursefamilypartnership.org
    - Healthy Families America, www.healthfamiliesamerica.org
- Compliance with sources of non-Federal Share - Sec. 1903 of the Social Security Act and applicable regulations
- Maryland HVS Pilot Program: Frequently Asked Questions (FAQs) - 6/7/17

Please complete the HVS Pilot application and return it to dhmh.healthchoicerenewal@maryland.gov no later than **5 p.m. ET on July 21, 2017**. Incomplete applications will not be considered. In order for this application to be considered complete for the purposes of submission, all components of the application must be completed, the application must be signed by an authorized representative of the Lead Entity, and all required components as summarized below must be included.

**PROJECT ABSTRACT**
Please provide a written general summary of the proposed Pilot initiative. The summary should be no longer than one page.

**PROJECT NARRATIVE**
Within Sections 1-6 below, make a written detailed statement about Lead and Participating Entities capabilities and proposed HVS Pilot scope. Please title and organize the project narrative according to the sections outlined in this RFA.

**Section 1: Community Health Pilot Lead Entity and Participating Entity Information; Readiness to Implement**

The purpose of this section is to provide information about the roles, responsibilities and requirements of the HVS Pilot Lead Entity and the other entities that will be participating in the HVS Pilot.

**1.1 Lead Entity Description**

DHMH will accept applications for the HVS Pilots from: Local Health Departments; Local Management Boards; a consortia of entities serving a county or region consisting of more than one county or city; or from a federally recognized tribe, or a tribal health program under a Public Law 93-638 contracted with the federal Indian Health Services. HVS Pilot application shall designate a "Lead Entity" that will be the single point of contact for DHMH. The Lead Entity is the governmental agency responsible for providing the required match for federal funding.

The HVS Pilot Lead Entity will enter into an agreement with DHMH that specifies general requirements of the HVS Pilot, including matching funding capability and ability to disperse funds, a data sharing agreement, performance measures, and reporting requirements. The Lead Entity is responsible for coordination, oversight and monitoring of the HVS Pilot.

Responsibilities of the Lead Entity include: Submit the Letter of Intent and Application; serve as the

organizing hub and contact point for the HVS Pilot; act as primary link to DHMH; collaborate with and facilitate the financial arrangement and payments with designated Participating Entities.

**1.2 Participating Entity Description**

In addition to the designation of a Lead Entity, the HVS Pilot application must identify the other entities that will participate in the HVS Pilot. These Participating Entities are the key community partners that will participate in the HVS Pilot's program delivery and may include: local entities providing home visiting services under current or future contract with the Lead Entity; Managed Care Organizations (MCOs); health services and specialty mental health agencies or departments; other public agencies or departments – such as county alcohol and substance use disorder programs, human services agencies, criminal justice/probation entities and housing authorities; or other entities that have significant experience serving the target population within the participating county or counties geographic area.

Responsibilities of the Participating Entity include: Collaborate with the Lead Entity to design and implement the HVS Pilot; provide letters of commitment; deliver services (if applicable); contribute to data sharing/reporting, including signing required data sharing agreements and complying with DHMH compliance policies and Pilot guidance.

**The Lead Entity must coordinate with the beneficiaries' Managed Care Organizations, whether or not MCOs are engaged as a Participating Entity**.

HealthChoice is the name of Maryland's statewide mandatory managed care program. The HealthChoice Program provides healthcare to most Medicaid beneficiaries. Eligible Medicaid beneficiaries enroll in a Managed Care Organization (MCO) of their choice and select a primary care provider (PCP) to oversee their medical care. In the HealthChoice Program, MCOs are responsible for providing the full range of health care services. In addition to providing Medicaid-covered services to those enrolled in the MCO, an MCO has specific standards and responsibilities concerning the provision of certain care including coordination of services for pregnant women and newborns. There are currently 8 MCOs participating in HealthChoice.

**1.3 HVS Pilot Lead Entity, Participating Entities, and Contact Persons**

Pilot applicants should complete the following table, and include this as part of their response to Section 1 in the Project Narrative.

| LEAD AND PARTICIPATING ENTITY TABLE | | | | | |
|---|---|---|---|---|---|
| **Name of HVS Entity** | **Lead or Participating** | **Address** | **Main Contact** | **Title** | **Role In Pilot** |
| | | | | | |

**1.4 Letters of Commitment and Support**

A Letter of Commitment from each of the anticipated Participating Entities is required as part of

application submission. Letters of Commitment should indicate the role the Participating Entities will serve in the Community Health Pilot and their capacity to perform proposed responsibilities.

Letters of Support from other relevant stakeholders in the geographic area where the HVS Pilot will operate are optional.

NOTE: Letters of Commitment and Support are not included as part of the HVS application page limit requirements.

**1.5 Lead Entity Capability Statement**

Describe and discuss the Lead Entity's experience with coordinating and collaborating with service providers, serving as a primary lead on multi-entity projects, overseeing and distributing program funds to other entities, ensuring deliverables are met, and reporting is accurate and timely. Specify any current or past activities related to the HVS Pilot in which the Lead Entity has been involved.

**1.6 Key Personnel**

Identify key personnel who will lead or manage the HVS Pilot project, their proposed role, and enclose copies of their resume with this application. Include the staffing plan for the program including the FTE of home visitors, home visitor supervisors, and other essential staff. (NOTE: Resumes are not included as part of the HVS application page limit requirements.) Include an organizational chart that reflects the operational and reporting structure of the Lead Entity.

**1.7 Pilot Daily Operations, Communication Plan, and Work Plan**

Describe the daily operational management structure for the HVS Pilot including who has decision-making authority and how Participating Entities will be involved in decision-making. Identify a main point of contact to support and coordinate with Participating Entities.

Describe the external communication plan that will be employed to communicate with MCOs, providers, beneficiaries, and stakeholders.

Describe how participating organizations will work together and the communications plan the HVS Pilot will employ. Describe how communication among the Lead Entity and Participating Entities will promote care integration and minimize silos.

Submit a work plan for the initial HVS Pilot year. Lead Entities may use or adapt the sample Work Plan Template in Appendix D, that indicates key project deliverables, timelines, and status. The Lead Entity should indicate in the Work Plan an anticipated enrollment timeline that accounts for variations in enrollment volume by quarter over the first year of implementation.

**Section 2: General Information - Pilot Vision and Need, Target Population, and Geographic Area**

The purpose of this section is for applicants to provide a vision for the HVS Pilot, describe the need, as

well as provide information on the target population(s) and geographic area(s) served.

**2.1 HVS Pilot Overview, Vision and Need**

Describe the overarching vision of how the HVS Pilot will: 1) build and strengthen existing efforts in the community and relationships, and improve collaboration among participating HVS Pilot entities; 2) provide opportunities for potential future local efforts beyond the term of this waiver; 3) demonstrate improvement in health outcomes and reduction in unnecessary and/or inappropriate services for the individual and/or family; and 4) explain how the HVS Pilot interventions and supports will be aligned with long-term community goals and objectives.

**2.2 Target Population(s) and Referral Process**

HVS Pilots must identify high-risk Maryland Medicaid beneficiaries that reside in the geographic area they serve, and assess their need. The target population will be drawn from those eligible for either Nurse Family Partnership (NFP) or Healthy Families America (HFA) programs as outlined in STC 29: Attachment D (Appendix B).

Lead and Participating Entities should explain their methodology for identifying their highest risk population from the pool of all women who would otherwise meet the eligibility criteria for services through either NFP or HFA.

HVS Pilot applicants could establish primary or secondary target groups as a way to prioritize their highest risk Medicaid population to engage in the HVS Pilot, for example:

| **Primary Risk Factors** | **Secondary Risk Factors** |
|---|---|
| ● Adolescent ≤ 15 years<br>● Late Registration > 20 weeks<br>● Abuse/Violence<br>● Alcohol/Drug Use (may target by substance)<br>● Less Than 1 year since last delivery<br>● History of fetal/infant death<br>● Non-compliance | ● Disability (mental/physical/developmental)<br>● Less than 12th grade education or no GED<br>● Lack of social/emotional support<br>● Housing/environmental concerns<br>● Smoking/tobacco use |

Describe the methodology used to identify the HVS Pilot target population(s), including data analyses and a needs assessment of the target population(s). Applicants are strongly encouraged to utilize existing Community Health Needs Assessments (CHNAs) or other related documents to describe the health need.

Describe how target beneficiaries will be screened, prioritized and referred to the proposed HVS Pilot program.

If the Lead Entity or Participating Entities offer or are involved in existing evidence-based home visiting

programs, describe the HVS program including total number of families served annually, number of trained home visitors and home visitor supervisors or other key staff, funding sources, and total annual operating budget.

Identify the target population(s) that will be served by the HVS Pilot, including an estimated total number of Medicaid beneficiaries to be served through the proposed HVS Pilot. Specify how this is an expansion of an existing home visiting services program by specifying the increased number of families to be served and additional staff that must be hired, if any, to fulfill the HVS Pilot goals.

**2.3 Geographic Area**

Describe the geographic area in which the HVS Pilot will operate, including a list of the ZIP codes, counties and incorporated cities that the proposed HVS Pilot will cover.

## Section 3: Strategies and Care Coordination

The purpose of this section is for the applicant to provide information on the services that will be provided under the proposed HVS Pilot, the service delivery strategies that will be employed, and how care will be coordinated.

**3.1 Strategies**

HVS Pilots must describe the strategies they will use to expand provision of evidence-based home visiting services to individuals at risk for poor birth and infant health outcomes. Pilots shall offer services as outlined in either of the two approved evidence-based practices for the HVS Pilot program, and submit proof of accreditation for the proposed model. Note: Proof of accreditation will not be counted towards the final application page count.

HVS Pilot applicants should describe the qualifications of the providers who will deliver the specified services under the chosen home visiting model, as per STC 29: Attachment D (Appendix B).

**3.2 Care Coordination**

For each target population, describe the specific care coordination strategies that will ensure an integrated continuum of care for the target population. Provide information on prior experience or other projects or programs that the applicant can draw upon in implementing the HVS Pilot and the existing programs and infrastructure that can be leveraged to support the HVS Pilot. Explain how the interventions will be successful in engaging and connecting individuals to medical, behavioral health, and social supports, improving health outcomes for the target population, decreasing avoidable emergency department and inpatient utilization, and decreasing avoidable utilization of other systems (e.g., jails, child protective services). If a certain intervention or other strategy will be limited to one, or some, target populations, please specify.

Discuss how the HVS Pilot will take current care coordination efforts into consideration and not duplicate those efforts.

Describe how the Lead and Participating Entities will coordinate with MCOs to address high risk medical conditions, and other Medicaid administrative services, such as Administrative Care Coordination Units (ACCUs).

**Section 4: Data Sharing, Data Management Plan, and Data Reporting**

The purpose of this section is for applicants to provide information on the data sharing and management framework for the HVS Pilot.

**4.1 Data Sharing and Management Plan**

Identify the data oversight and management structure for the HVS Pilot. For each target population, describe how data collection, management, and sharing will occur between the Lead and Participating Entities. Describe the overall plan for tracking and documenting progress of the HVS Pilot as a whole, as well as for each type of Participating Entity and each target population.

Provide information on the tools and/or systems that will be utilized to support data sharing, the capabilities currently in place and any new development that will be needed to support data sharing under the HVS Pilot. Include in the work plan a timeline and implementation plan for making certain that the necessary systems, tools, and data use agreements to support data sharing are in place. Indicate anticipated challenges and strategies the HVS Pilot will employ to manage data tools (see Appendix D: Work Plan Template).

To the extent any shared data contains Personal Health Information/Personal Information (PHI/PI), mental health or substance use disorder services information, the Lead Entity and its Participating Entities must comply with all applicable state and federal law. Final approval of this application will be subject to the Lead Entity's mandatory agreement to the forthcoming Inter-Agency Agreement and Data Use Agreement, which will govern the exchange and utilization of the data involved in the HVS Pilot.

**4.2 Data Reporting**

HVS Pilot Lead Entities are required to submit quarterly and annual reports to DHMH. DHMH will issue reporting template/format with instructions at a later date. The purpose of the annual report is to demonstrate that the HVS Pilot is conducted in compliance with the requirements set forth in the STCs, RFA, any agreement between DHMH and the Lead Entity, and guidance from DHMH.

Describe the plan for ongoing data collection at the local level and data reporting to DHMH. Data will be required at the Medicaid beneficiary level, including at minimum, the beneficiary's Medicaid number; if that is not available, the first and last name, date of birth, and social security number. Describe how HVS providers will use an electronic performance management system (for example, the ETO system or PIMS) and if it is currently in place, needs modification, or needs to be developed.

As a requirement of funding, Lead and Participating Entities are required to make available program and financial data to DHMH in the form, manner, and timeframes requested in the final agreement. Moreover, pursuant to 42 CFR § 431.107(a)(b)(1)(2), providers must agree to create and maintain all records necessary to fully disclose the extent and eligibility for services provided by the provider to

individuals in the Medicaid program, as well as any information relating to payments claimed by providers for furnishing HVS Pilot services.

## Section 5: Monitoring and Evaluation Plan

The purpose of this section is for the applicant to provide information on the performance measures the HVS Pilot will use to track progress, the method to demonstrate quality improvement; and the ongoing monitoring of the Participating Entities' performance. Final approval of this application will be subject to the Lead Entity's mandatory agreement to the forthcoming Inter-Agency Agreement and Data Use Agreement, which will govern the exchange and utilization of the data involved in the HVS Pilot.

Lead Entities will agree to participate in the collection and monitoring of required performance measures for each type of Participating Entity and the HVS Pilot itself (see Appendix E). Pilots will be required to report metrics in order to assess their success in achieving program goals and strategies. All Pilots must report metrics quarterly and annually unless otherwise specified.

### 5.1 Performance and Process Measures

The HVS Pilot is an opportunity for communities to be able to clearly demonstrate if, in fact, evidence-based HVS with the support of Medicaid funding in Maryland is a sustainable model that improves health outcomes and reduces costs.

Currently 21 out of 24 Maryland county health departments (including Baltimore City) offer evidenced based HVS through the Federal Home Visiting Program (MIECHV) administered by HRSA. MIECHV has established multiple performance indicators of which DHMH has adopted a subset for the purposes of the HVS Pilot evaluation. The decision to limit HVS Pilot measures to a subset is based on several factors. Primarily, the HVS Pilots are designed to demonstrate evidenced-based HVS value to the Medicaid program and to align with goals of the CMCS Maternal and Infant Health Initiative and CMS's Child Core Set Measures.

The Lead Entity should provide an attestation of its agreement to collect and report on the following performance measures. DHMH reserves the right to modify the performance measures that will be required from the Lead Entity. Details on the metrics are provided in Appendix E.

| Performance Measures |
|---|
| All Cause Emergency Room Visits* |
| Inpatient Hospital Admission Rate* |
| Potentially Avoidable ER Utilization* |
| Maternal Depression Screening |
| Well Child Visits* |
| Postpartum Visits* |
| Very Low Birth Weight* |
| Receipt of Treatment for Maternal |

| |
|---|
| Depression* |
| Postpartum Contraception* |
| Dental Care Utilization* |
| Tobacco Cessation |
| Lead Poisoning Screening* |
| Preterm Birth |

**Denotes a performance measure that DHMH will evaluate using Maryland Medicaid claims data (MMIS) and participant information provided by the Home Visiting Services Pilot Program awardees.*

The Lead Entity should provide an attestation of its agreement to collect and report on the following process measures. In addition to referenced process measures, Lead Entities should propose two additional process measures. DHMH reserves the right to modify the process measures that will be required from the Lead Entity.

| **Process Measures** |
|---|
| Participant Attrition Rate |
| Number of Home Visits Completed Per Month |
| Caseload Per Home Visitor |
| Enrollment Rate Per Month |
| Participant Demographic Information |
| Number of Beneficiaries Served Per Month |
| Proposed Process Measure: |
| Proposed Process Measure: |

**5.2 Demonstrating Quality Improvement**

Explain the approach for quality improvement and change management that the Lead Entity plans to use. Explain how the HVS Pilot will identify needed adjustments, a process for carrying out the change, and a process for observing and learning from the implemented change(s). Select a tool such as Plan-Do-Study-Act, or an alternate quality improvement process.

Describe the Lead Entity's plan to conduct ongoing monitoring of the Participating Entities and to make subsequent adjustments if issues are identified. Include a process to provide technical assistance, impose corrective action, and terminate the HVS Pilot if poor performance is identified and continues.

## Section 6: Budget Plan and Financing Structure

The purpose of this section is to outline the components of the Lead Entity's budget, financing structure, and rate development responsibilities.

The HVS Pilot will align with the State of Maryland's fiscal year, beginning on July 1 and ending on June 30 of each year. Up to $2.7 million in matching federal funds are available annually, and when combined

with the local non-federal share, HVS Pilot expenditures may total up to $5.4 million annually. Available funding in Pilot Year 1 is based on approval of the HVS Pilot application submission and is subject to the Lead Entity's mandatory agreement to the forthcoming Inter-Agency Agreement and Data Use Agreement, which will govern the exchange and utilization of the data involved in the HVS Pilot. Additionally, approval is contingent on CMS review and concurrence with the HVS Pilot's per visit rate request and underlying rate composite.

*State Payment to Lead Entities*

A Lead Entity must be a Local Health Department (LHD) or other local government entity, such as a local management board (see Section 1.1. for allowable Lead Entity types). Each Lead Entity must have the ability to provide the non-federal share of payment through an intergovernmental transfer (IGT) process. The Lead Entity shall process an IGT of funds to DHMH in the amount specified. DHMH will make payment of both the non-federal and federal share for home visiting services rendered by the Lead Entity.

*Lead Entity Payment to Participating Entities*

If the Lead Entity chooses to contract with one or more entities to provide home visiting services, DHMH expects each Lead Entity will follow its own local government procurement or grant sub-contracting protocol in accordance with the DHMH Human Services Agreement Manual. Lead Entities shall describe and diagram the flow of funds (see Section 6.2 for additional instruction) among Participating Entities, have appropriate contracts and/or memorandums of understanding, data use agreements and business associate agreements in place that describe roles, services, charges, data sharing, and record keeping and reporting requirements. Within those parameters, DHMH anticipates that the Participating Entities will invoice the Lead Entity for contracted services on a monthly basis based on the approved per visit rate for home visiting services provided.

*Funding Request Details*

Pilot payments are intended to support the HVS Pilots for:

1. Expansion of current evidence-based home visiting activities in a jurisdiction
2. Increased coordination and appropriate access to care for the highest risk beneficiaries

Funding assumptions will be derived based on a "per home visit service rate" that shall be developed and proposed by the Lead Entity.

Budgets should not include costs for services directly reimbursable with Medicaid or other federal funding resources. Federal financial assistance from the Medicaid program cannot be used to provide services to individuals not eligible for Medicaid services. All funds related to HVS Pilot programs must be maintained and reported as distinct and separate from any other sources of funding. All funding shall be for the direct service delivery of HFA and/or NFP evidence-based home visiting services to Medicaid beneficiaries.

**6.1 Financing Structure**

Describe the oversight and governance structure that will oversee the payment process between the Lead Entity and DHMH, and between the Lead Entity and Participating Entities, if applicable. Explain how payments will be tracked and specify how the applicant will ensure funds are sufficient to provide reimbursement for provided services.

**6.2 Funding Flow Diagram**

Using the sample Funding Flow Diagram in Appendix F, create a funding diagram that illustrates the flow of requested funds from DHMH to the Lead Entity and to Participating Entities, if applicable. Make certain that the funding diagram reflects whether services will be provided directly by the Lead Entity or through Participating Entities.

**6.3 Non-Federal Share**

Using the "Sources of Non-Federal Share" sample table below, list the sources and amount of each local funding stream that is contributing to the non-federal share. HVS Pilot Applicants must also include non-federal share source description as part of the Budget Narrative.

| **Sample Table: Sources of Non-Federal Share** | | | | |
|---|---|---|---|---|
| **Local Funding Source (non-Federal Share)** | **Local Funding Amount** | **Approved/confirmed with authorized representative** | **Federal Matching Funding Amount Request** | **Proposed Total Pilot Funds** |
| *ABC County Tax Revenue* | *$100* | *Yes: County Controller Jane Smith* | *$100* | *$200* |
| *ABC County Core Funding* | *$100* | *Yes: County Health Officer John Smith* | *$100* | *$200* |
| *ABC County Other Permissible Source* | *$100* | *Yes: Grant Officer Beau Smith* | *$100* | *$200* |
| *Total Proposed Funds* | *$300* | | *$300* | *$600* |

**6.4 Non-Duplication of Payments and Allowable Use of Federal Financial Participation**

HVS Pilot applicants must complete and submit with each application the Attestation: Non-Duplication of Funds and Allowable Use of Federal Matching Funds (Appendix G).

**6.5 Funding Request**

The HVS Pilot is a demonstration project to test innovative and cost-effective programs and payment structures within Medicaid. To this end, DHMH is looking for Lead Entities and their partners to develop a per unit rate for direct services based on their experience and knowledge of providing maternal and child health services. Thus, DHMH has not defined specific parameters around the per visit rate methodology and looks to the Lead Entities to create a proposed rate and corresponding budget that is made up of the necessary components of the direct service costs of providing HVS. DHMH will evaluate proposed rates to determine if they seem reasonable.

*HVS Rate Development*

The Lead Entity should develop its funding request based on a per home visit rate (per unit cost). As described in the following excerpt from STC 29: Attachment D (Appendix B), allowable components that make up a home visiting services rate (per unit cost):

> *"...The unit cost that will be based on such things as, estimated salary costs, travel cost, reporting costs, and other reasonable and necessary expenditures divided by the number of expected number of visits. The expected number of visits will be based on the model, the number of beneficiaries to be served, and the number of home visitors. DHMH will evaluate the reasonableness of the unit cost and total payment. DHMH anticipates that the initial quarterly payments will be prospective, and thereafter retrospective based on the Lead Entity's actual HVS services rendered. In turn, DHMH anticipates that the HVS provider will invoice the Lead Entity monthly or quarterly for home visits provided to a specific Medicaid beneficiary based on the Lead Entity and HVS provider's contractually agreed upon payment schedule. Lead Entities are expected to submit a budget proposal and narrative that reflects average expected evidence-based home visiting frequency and intensity, taking into account the potential for variations, that is, accommodating for those few cases that may require more intense visits."*

DHMH recognizes that developing a per home visit rate may be challenging given that many existing evidenced-based Home Visiting programs are not currently structured using a per-visit unit cost. Following release of this RFA, additional individualized technical assistance will be offered to interested entities on home visiting rate development. HVS Pilot applicants should indicate interest in participating in this individualized technical assistance offering for rate development in their Budget Narrative.

A discussion of cost and rate development methodologies for Evidence-based HVS programs may be found in the Mathematica Policy Research study "Cost of Early Childhood Home Visiting: An Analysis of Programs Implemented in the Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment Initiative." Additional resources that may be useful for HVS rate development will be posted on the DHMH website, and shared with interested entities as they become available.

*HVS Budget Development*

For Budget Year 1, the HVS Pilot application's budget narrative must include a proposed home visiting

service rate with a break out of all reasonable and necessary expenditures associated with providing direct home visiting services. For Budget Year 1, include quarterly projections of the expenditures contributing to the per home visit rate that makes up the requested budget. Specify the number of years that the Lead Entity expects the HVS Pilot to operate; Pilots may choose to participate for the entire 4.5 year period. For additional years of anticipated Pilot operation (Budget Years 2-4.5) only provide the total projected dollar amount per year.

DHMH will pay the Lead Entity on a quarterly basis for home visiting services rendered (per unit cost). The Lead Entity may request a one-time prospective payment for projected expenditures in the first quarter. If a Lead Entity requests a prospective payment, it must justify the need for this payment in the budget narrative. In order to be considered for a prospective payment, the accompanying budget narrative must reflect the number of beneficiaries expected to enroll in the initial quarter of program implementation and the number of home visits to be completed in the first quarter. Subsequent retrospective payment will be adjusted depending on actual services provided in the first quarter.

HVS Pilot funds are limited to payment for direct service delivery. If funds are needed for administration costs (e.g. computers) these may not be paid for by HVS Pilot funds. Funds for such expenditures are are not available via this HVS Pilot but these funds should be described and quantified in the budget narrative if they are necessary to enable HVS Pilot service provision within the first year.

The Lead Entity will supply IGTs solely for the payment of services authorized under the demonstration.

HVS Pilot applicants should complete the following table and include as part of the Budget Narrative:

| Number of Target Beneficiaries Per Year (A) | Average number of visits per beneficiary per month (B) | Total expected number visits per month (A*B) = C | Total expected number visits per quarter (C*3)=D | Total expected number of visits per year (D*4)=E | Total Budget Requested (E*Home visit Rate) |
|---|---|---|---|---|---|
| *For example: 50* | *4* | *200* | *600* | *2400* | *$240,000* |

In addition to the budget narrative, HVS Pilot applicants will need to complete the DHMH Budget Package 4542 (Appendix H). Although the Lead Entity may calculate the proposed per visit rate as its basis for the total aggregate budget request outside of the DHMH 4542, the use of DHMH 4542 forms is necessary to qualify for the HVS Pilot award. The line item expenditures included in the DHMH 4542 should align with the Budget Narrative and total budget request. Budgets should not include costs (e.g., payments) for services reimbursable with Medicaid or other federal funding resources.

**APPLICATION APPENDICES**

A. Application Requirements
B. Special Terms and Conditions (STC) 29 – Attachment D: Evidence-Based Home Visiting Services Pilot Protocol, Approved: April 27, 2017
C. Application Selection Criteria
D. Work Plan Template
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F. Sample Funding Diagram
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## APPENDIX A. APPLICATION REQUIREMENTS

A summary of required Application components for submission by Lead Entities includes:

1. Project Abstract (no longer than one page);
2. Project Narrative (maximum 15 pages, 12 pt. font, single spaced, one (1) inch margins);
3. Budget Narrative and Budget Form 4542 (maximum 3 pages);
4. Letters of Commitment from all proposed participating HVS Pilot entities;
5. A funding diagram, modified from the sample, illustrating how the requested funds would flow either: 1) from the Lead Entity to Participating Entity(ies)and back to the Lead Entity and how the funds would be distributed among Participating Entities (See Section 6.2 and Appendix F), or 2) if the Lead Entity is the provider of direct services
6. Proof of Nurse Family Partnership or Health Families America accreditation;
7. (Optional) Letters of support from relevant stakeholders;
8. Resumes of Key Personnel
9. A signed and dated copy of Appendix G: Attestations and Certifications

**APPENDIX B. SPECIAL TERMS AND CONDITIONS (STC) 29: Attachment D**

Per STC 29, the following protocol includes additional information about the evidence-based home visiting services (HVS) pilot program.

As described in STC 29, the pilot program provides evidence-based home visiting services by licensed practitioners or model trained home visitors to promote health outcomes, whole person care, and community-integration for high-risk pregnant women and children up to two (2) years old. The services are described in Table One: Description of Services below which are based on evidence-based program requirements. The provider qualifications are described in Table Two: Provider Requirements below which include provider titles, licensure (if applicable), certification, (if applicable), education, training, and experience requirements. The HVS pilot program is aligned with two evidence-based models focused on the health of pregnant women and infants.

a. Nurse Family Partnership (NFP): The NFP is designed to reinforce maternal behaviors that encourage positive parent child relationships and maternal, child, and family accomplishments. The HealthChoice section 1115 demonstration NFP pilot program will adhere to the NFP national program standards and service will be suspended once the child reaches two (2) years old.

b. Healthy Families America (HFA). The HFA model targets parents facing issues such as single parenthood, low income, childhood history of abuse, substance use disorder (SUD), mental health issues, or domestic violence. The HealthChoice section 1115 demonstration HFA pilot program will adhere to the HFA national program standards and service will be suspended once the child reaches two (2) years old.

The services are described in Table One: Description of Services below.

**Table One: Description of Services**

| Service | Description of Service |
|---|---|
| **Prenatal Home Visit** | The HVS Pilot Project will provide home visit services to Medicaid eligible expectant mothers during their pregnancy. The prenatal home visit services will provide:<br><br>• Monitoring for high blood pressure or other complications of pregnancy (NFP only);<br>• Diet and nutritional education;<br>• Stress management;<br>• Sexually Transmitted Diseases (STD) prevention education;<br>• Tobacco use screening and cessation education;<br>• Alcohol and other substance misuse screening and counseling;<br>• Depression screening; and<br>• Domestic and intimate partner violence screening, education and safety planning. |
| **Postpartum Home Visits** | The HVS Pilot Project will provide home visit services to Medicaid eligible mothers during their sixty (60) day postpartum period.<br><br>• Diet and nutritional education; |

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| | • Stress management;<br>• STD prevention education;<br>• Tobacco use screening and cessation education;<br>• Alcohol and other substance misuse screening and counseling;<br>• Depression screening;<br>• Domestic and intimate partner violence screening, education and safety planning;<br>• Breastfeeding support and education (NFP may refer Medicaid beneficiaries out to a lactation specialist, but the lactation consultant services are not covered as a home-visiting service);<br>• Guidance and education with regard to well woman visits to obtain recommended preventive services;<br>• Medical assessment of the postpartum mother and infant (NFP only);<br>• Maternal-infant safety assessment and education e.g. safe sleep education including Sudden Infant Death Syndrome (SIDS) prevention<br>• Counseling regarding postpartum recovery, family planning, needs of a newborn;<br>• Assistance for the family in establishing a primary source of care and a primary care provider (i.e. ensure that the mother/ infant has a postpartum/ newborn visit scheduled);<br>• Parenting skills and confidence building (HFA emphasis). |
| **Infant Home Visits** | The HVS Pilot Project will provide home visit services to newborn infants born to HVS Pilot Project beneficiaries until the child reaches two (2) years of age.<br><br>• Breastfeeding support and education (NFP may refer Medicaid beneficiaries out to a lactation specialist, but the lactation consultant services are not covered as a home-visiting service); and<br>• Child developmental screening at major developmental milestones from birth to age two (2);<br>• Parenting skills and confidence building (the HFA program emphasizes these skills). |

Both HFA and NFP evidence-based practice models specify an array of services that may be provided to meet the needs of the family.

The HFA program model meets the criteria established by the U.S. Department of Health and Human Services (HHS) for an "evidence-based early childhood home visiting service delivery model." Goals include reducing child maltreatment, improving parent-child interactions and children's social-emotional well-being, and promoting children's school readiness. HFA Model program components include 1) screenings and assessments to determine families at risk for child maltreatment or other adverse childhood experiences; 2) parent education and support services; and 3) routine screening for child development and maternal depression as well as screening for domestic violence and substance abuse. In the case of a positive screen, the individual is referred for appropriate treatment services. In such cases, care coordination may also occur if consent is provided by the parent. If consent is provided, home visitors may refer participants out to external resources and providers. The type of referral may vary depending upon the type of service required. With additional consent, home visitors will liaise with the provider to ensure coordination of care. In addition, many sites offer services such as parent support groups and father involvement programs.

Home visitors complete training modules specific to each program model that include such topics such as keeping babies healthy and safe, fostering infant and child development, and promoting mental health. Thus, HFA model services offered to mothers may include both teaching basic parenting skills, and training parents on how to manage a child's medical, behavioral, and/or developmental treatment needs.

The NFP program model also meets the criteria established by DHHS for an "evidence-based early childhood home visiting service delivery model." The program model is designed for first-time, low-income mothers and their children, and is designed to improve 1) prenatal health and outcomes; 2) child health and development; and 3) families' economic self-sufficiency and/or maternal life course development. NFP home visitors use input from parents, nursing experience, nursing practice, and a variety of model-specific resources coupled with the principles of motivational interviewing to promote low-income, first-time mothers' health during pregnancy, care of their child, and own personal growth and development. NFP program model, therefore, may also address both teaching basic parenting skills, as well as training parents on how to manage a child's medical, behavioral, and/or developmental treatment needs.

The provider qualifications for the services provided are described in Table Two: Provider Qualifications below.

**Table Two: Provider Qualifications**

| *Home Visitor Provider Qualifications* | | | | |
|---|---|---|---|---|
| Home Visitors | Education (typical) | Experience (typical) | Skills (preferred) | Training |
| Healthy Families America Home Visitors – Must be hired by an HFA affiliated or accredited agency | Bachelor's Degree in Behavioral Sciences (Social Work, Psychology, Sociology, Mental Health, Nursing and Education) preferred; Associate's Degree in Human Services or related field. May have high school diploma or GED. | 3-5 years' experience working in Human or Social Services; 1 year working with or providing services to children and families; Case management or service coordination experience preferred; Experience and willingness to work with a culturally diverse population. A Master's Degree in nursing, public health, social work or a relevant human services field may be substituted for one year of the required experience. | Oral and written communication skills; Ability to develop trusting relationships; Ability to maintain professional boundaries; Acceptance of individual differences; Knowledge of infant and child development; Openness to reflective practice. | Must meet HFA program training requirements, including: Core Training; Curriculum training; Wraparound training; customized advanced training; any additional program based continuing education training requirements. |

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| Nurse Family Partnership (NFP) Nurse Home Visitors –Hired by approved Nurse Family Partnership implementing agency | Registered nurse (RN) with Baccalaureate degree in nursing; may have additional degrees beyond BSN such as MSN or, other related/advanced practitioner designations e.g. nurse practitioner, nurse midwife; current licensure. | At least 5 years' experience in public health nursing, maternal and child health, behavioral health nursing, pediatrics, or other fields. May have American Heart Association HealthCare provider CPR (Cardiopulmonary Resuscitation) and valid AED (automated External Defibrillator) certification.<br>A Master's Degree in nursing or public health may be substituted for one year of the required experience. | Technical skills: Providing care mgmt. and care coordination to high-risk populations; understanding and applying federal, state, local, and grant program regulations and policies in a public health environment; Leadership skills, interpersonal and relationship building; communication and quality improvement analysis skills | Comprehensive training and preparation as required by NFP model. |
| Nurse Home Visitor Supervisor – Hired by approved Nurse Family Partnership implementing agency | Registered nurse (RN) with Baccalaureate degree in nursing. Preferred that nurse supervisors have additional degrees beyond BSN such as MSN or, other related/advanced practitioner designations e.g. nurse practitioner, nurse midwife. | At least 5 years' experience in public health nursing, maternal and child health, behavioral health nursing, pediatrics, or other fields. May have American Heart Association HealthCare provider CPR (Cardiopulmonary Resuscitation) and valid AED (automated External Defibrillator) certification.<br><br>A Master's Degree in nursing or public health may be substituted for one year of the required | Nurses must receive reflective supervision weekly to meet requirements of the evidence based program. This nurse supervision is part of the direct services provided. Nurse supervisors may conduct home visits as required to support nurses and/or beneficiaries level of care needs. For example, if a child or caregiver is ill for a month, a Nurse Home Visitor Supervisor may visit the home to re-assess the caregiver | Comprehensive training and preparation as required by NFP model. |

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| | | experience. | and child and offer an appropriate level of care. | |

**Description of Payment Methodologies**

The Department of Health and Mental Hygiene (DHMH) will pay Lead Entities (LE) (local health departments/ county governments) for home visiting services provided at a home visit rate. The home visit rate shall not exceed the amount expended by the Lead Entity for furnishing the direct service of the provider. The home visit rate will be developed based on a target cost per visit, adjusted for factors specific to the lead agency, such as the particular evidence-based practice, along with variables such as salary costs, type of visit, intensity of visit, and duration of visit or contracted evidence-based practice provider unit costs. Payment will be withheld if Lead Entities do not report required data to DHMH in a timely and complete manner as outlined and agreed upon in applicable data use agreements.

Both the HFA and NFP evidence-based home visiting programs tailor home visiting services and the number of visits to the needs of each family. Frequency of home visiting may vary from family to family, but must remain within the scope of the evidence-based programs. Below are the home visiting frequency and intensity protocols for HFA and NFP.

Healthy Families America: HFA sites offer at least one home visit per week for the first six (6) months after the child's birth. After the first six (6) months, visits might be less frequent. Visit frequency is based on families' needs and progresses over time. Typically, home visits last one hour. HFA sites begin to provide services prenatally or at birth and continue for this Pilot demonstration up to age two (2).

Nurse Family Partnership: NFP nurses conduct weekly home visits for the first month after enrollment and then every other week until the baby is born. Visits are weekly for the first six (6) weeks after the baby is born, and then every other week until the baby is twenty (20) months. The last four (4) visits are monthly until the child is two (2) years old. Home visits typically last 60 to 75 minutes. The visit schedule may be adjusted to meet client needs.

NFP recommends that programs begin conducting visits early in the second trimester (14–16 weeks gestation) and requires programs to begin visits by the end of the 28th week of pregnancy. Clients graduate from the program when the child turns two (2) years old.

**Table Three: Healthy Families America (HFA) Agencies in Maryland with Accreditation Status**

| Jurisdiction | Agency | Current Status |
|---|---|---|
| Allegany | Health Department | Affiliated |
| Baltimore County | Health Department | Accredited |
| Baltimore City | Family League | Accredited |
| Calvert County | Public Schools | Accredited |
| Charles County | Center for Children | Accredited |
| Dorchester | Health Department | Accredited |
| Frederick | Mental Health Association | Accredited |

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|---|---|---|
| Garrett | Health Department | Accredited |
| Harford | Health Department | Affiliated |
| Howard | Howard General Hospital | Accredited |
| Lower Shore (Somerset) | Eastern Psych Association | Accredited |
| Mid Shore | Health Department | Accredited |
| Montgomery | Family Services | Accredited |
| Prince George's | Dept. Family Services | 2 Sites Accredited; 1 site Affiliated |
| Washington | Health Department | Accredited |
| Wicomico | Health Department | Accredited |

## APPENDIX C. APPLICATION SELECTION CRITERIA

The Maryland HealthChoice §1115 Waiver HVS Pilot application evaluation is a competitive process that will result in the selection of qualified HVS Pilots based on the program need, quality and scope of their application. The Department of Health and Mental Hygiene (DHMH) will conduct the evaluation process in two phases: (1) Quality and Scope of Application, and (2) Funding Decision. HVS Pilot applications that do not meet the basic requirements of the Special Terms and Conditions (STC): Attachment D: Evidence-Based Home Visiting Services Pilot Protocol, and DHMH application guidance will be disqualified.

### Overview

Program Need, Quality and Scope of Application. HVS Pilot applications will be assigned a numerical score of up to 100 points based on the jurisdiction's need for HVS Pilot services, and the quality and scope of the application. Applications must receive a pass score on all pass/fail criteria to be eligible to participate.

Funding Decision. The funding amount for each HVS Pilot will be determined based upon the reasonableness of the funding request, the amount requested, and the justification and/or methodology used to develop the service costs.

There will be a review period after DHMH receives applications that will allow DHMH to ask clarifying questions to Pilot Applicants. Pilot Applicants' responses may influence their final score.

If the HVS Pilot Applicant (Lead Entity and/or Participating Entity) is currently out of compliance or delinquent on any DHMH corrective action, the HVS Pilot Applicant is not eligible for funding.

### Applications Will Be Assigned a Numerical Score

Scoring criteria will help DHMH assess whether applications meet the pilot goals and requirements outlined in Maryland HealthChoice 1115 Waiver's STCs.

Each application will be assigned a numerical score based on a possible total of 100 points. Multiple DHMH reviewers, representing both Medicaid and Public Health Administrations within DHMH, will score applications and then assign a total average score.

*Highest Possible Score by Application Section*
Section 1: Community Health Pilot Lead Entity and Participating Entity Information; Readiness to Implement (up to **5 points)**
Section 2: General Information - Pilot Vision and Need; Target Population; Geographic Area (up to **10 points)**
Section 3: Strategies and Care Coordination (up to **25 points)**
Section 4: Data Sharing, Data Management Plan, and Data Reporting (up to **15 points)**

Section 5: Monitoring and Evaluation Plan (up to **15 points)**
Section 6: Budget Plan and Financing Structure (up to **30 points)**
Attestations and Certification - **Pass/Fail**
**Total Possible Points: 100**

**Application Sections Will Be Scored Based on Specified Criteria**
Each application section will be scored based on the criteria specified below:

**General Considerations:**

- Application was received in the dhmh.healthchoicerenewal@maryland.gov mailbox by July 21, 2017.
- Application includes a project abstract summary no longer than one page.

**Project Narrative:**
**Section 1: Community Health Pilot Lead Entity and Participating Entity Information; Readiness to Implement (up to 5 points)**

1.1 Lead Entity Description

- Organization submitting the application meets Lead Entity requirements as outlined in STC 29 , and all required information is provided

1.2 Participating Entities Description

- Meets Participating Entity requirements as outlined in STC 29
- Information is complete
- Explanation of role in Pilot is clear and appropriate given the target population and selected strategies

1.3 HVS Pilot Lead Entity, Participating Entities and Contact Persons

- Organization fills out table with all relevant information

1.4 Letters of Commitment and Support

- Lead Entity attaches Letter of Commitment for all proposed Participating Entities
- Letters of Support are optional but help attest to Lead Entity capability or need

1.5 Lead Entity Capability Statement

- Demonstrates organization's capabilities to serve as a Lead Entity on this Pilot initiative.
- Explains organization's experience and expertise in coordinating and collaborating with service providers
- Demonstrates experience:
    - serving as a primary lead on multi-agency/multi-entity projects
    - overseeing and distributing program funds to other entities
    - ensuring deliverables are met and reporting is accurate and timely

- Provides examples and explains role in current or past projects/programs/activities related to the HVS Pilot for which the LE is applying (i.e., evidence-based home visiting)

1.6 Key Personnel

- Identifies key personnel who will lead or manage the HVS Pilot project, their proposed role, and enclose copies of their resume(s) with the application
- Includes a clear Staffing Plan

1.7 Pilot Daily Operations, Communication Plan, and Work Plan

- Clear and comprehensive plan for collaboration and communication between entities
- Clear plan to communicate state pilot requirements from the Lead Entity to Participating Entities
- Clear plan to communicate externally with stakeholders and other interested parties
- Structure and process planned for making decisions
- Includes detailed work plan (Appendix D)outlining implementation dates, tasks and key deliverables

**Section 2: General Information - Pilot Vision and Need, Target Population, and Geographic Area (up to 10 points)**

2.1 HVS Pilot Overview, Vision and Need

- Uses evidence to define community need for Pilot
- Pilot design is comprehensive, cohesive and well-designed to achieve goals
- Demonstrates how the HVS Pilot will address community and target population needs
- Articulates strategies to build sustainable processes and linkages that can support program operations across the delivery systems in the near term and beyond the term of the HVS Pilot
- Explains how anticipated program outcomes are achieved through Pilot interventions and supports

2.2 Target Population(s) and Referral Process:

- Proposed target population meets criteria outlined in STC 29
- Identifies number of people proposed to be served through the HVS Pilot and the additional staff
- Describes plan for participant identification, prioritization and outreach
- Provides methodology used and rationale to define target population(s)
- Target population(s) is/are appropriate given participating entities and strategies
- Describes current HVS program in detail, if applicable
- Describes how proposed HVS pilot is an expansion of existing HVS, if applicable

2.3 Geographic Area

- Describes geographic area in which the HVS Pilot will operate, including counties and zip codes

**Section 3: Strategies, and Care Coordination (up to 25 points)**

3.1 Strategies

- Describes evidence-based HVS practice model to be implemented
- Affirms that services do not duplicate any other Medicaid covered service
- Provide proof of selected model accreditation

3.2 Care Coordination

- Meets requirements as outlined in STC 29
- Justifies appropriateness of services and interventions for target population(s)
- Describes alignment with other concurrent initiatives being implemented in the region (e.g., does the applicant articulate a vision of how initiatives fit together)
- Describes extent of process and linkages planned or in place to implement intervention, demonstrating complete consideration of the necessary partnerships to support the HVS Pilot
- Demonstrates engagement and cooperation with MCOs and PEs to make certain that safeguards are in place that reduce potential of overlap or gaps in providing services to participants

**Section 4: Data Sharing, Data Management Plan, and Data Reporting (up to 15 points)**

4.1 Data Sharing and Management Plan

- Demonstrates ability to support data sharing between entities and identifies existing resources for data sharing and actions necessary to close existing gaps
- Clearly presents data sharing processes and expectations of data sharing partners (or the process to identify them)
- Presents a comprehensive plan and approach to data safeguards, oversight and protections
- Presents a comprehensive timeline and implementation plan for data sharing, data management and completion of data sharing agreements.

4.2 Data Reporting

- Provides a clear and comprehensive plan for ongoing data collection, reporting, and analysis of interventions

**Section 5: Monitoring and Evaluation Plan (up to 15 points)**

5.1 Performance and Process Measures

- Attests to agree to collect and report on the enclosed performance and process measures
- Provides two additional process measures
- Meets performance and process requirements

5.2 Demonstrating Quality Improvement

- Describes a clear and comprehensive plan for quality improvement
- Demonstrates resources and organizational capacity to conduct ongoing Participant Entity monitoring and make adjustments as needed
- Provides comprehensive plan for providing technical assistance, imposing corrective action, and terminating if poor performance is identified and continues with Participating Entities

**Section 6: Budget Plan and Financing Structure (up to 30 points)**

6.1 Financing Structure

- Clearly demonstrates and affirms that total computable of Pilot funding will be used only for direct services cost to contracted providers, or in the case of the LE providing services that total computable is for direct services costs only
- Demonstrates a comprehensive approach to flow of funds, how reimbursement will take place, payment schedule and oversight and monitoring of payment

6.2 Funding Flow Diagram

- Provides a clear diagram explaining how the payment process will function

6.3 Non-Federal Share

- List of the entities, sources, and total dollar amount that will make up the non-federal share from the Lead Entity to be used for payments under the HVS Pilot

6.4 Non-Duplication of Payment and Allowable Use of Federal Financial Participation

- Attests to non-duplication of funds and allowable use of federal matching funds

6.5 Funding Request

- Clearly demonstrates the cost factors and costs that contribute to the direct services rate developed for the HVS Pilot
- Clearly demonstrates how the total budget request is derived from proposed visits
- If requesting a prospective payment, clearly outlines the anticipated number of people to be served in the first quarter, total number of anticipated visits in the first quarter and justifies the need for a prospective payment
- Completely fills out and submits the funding equation table
- Completes the Budget Form 4542 with appropriate line items; the total should match the proposed budget total
- Thoroughly explains budget line items, rate methodology and HVS rate per visit, total budget request in the Budget Narrative.
- DHMH will determine the appropriateness of the funding request in the context of the reasonableness and soundness of the interventions to be provided, the clarity of the governance structure, presence of oversight mechanisms and internal controls to ensure payment and accountability related to Participating Entities, the needs of the target population, and the

assurances that payments are not duplicative of payments for existing Medicaid services

**Section 7: Attestations and Certification-Pass/Fail**

Pass = Applicant checks box and provides signature

Fail = Applicant does not check box and/or does not include a signature. Applicant may not participate in a pilot unless Section 7 receives a score of "Pass."

**APPENDIX D. WORK PLAN TEMPLATE**

**Home Visiting Services (HVS) Pilot Project Work Plan**
**July 1, 2017 – June 30, 2018**

**Quarter (Select one)**

- ☐ **Quarter 1, 7/1/17 – 9/31/17**
- ☐ **Quarter 2, 10/1/17 – 12/31/17**
- ☐ **Quarter 3, 1/1/18 – 3/31/18**
- ☐ **Quarter 4 (Final), 4/1/18 – 6/30/18**

**Year 1 Project Goal**
[Lead Entity to enter]

**Year 1 Project Deliverables** – *The deliverables below should be taken from appropriate sections of the HVS Pilot applications and should be written as SMART objectives or activities in your work plan. You can combine multiple deliverables in a single objective.*

**Objective 1:**

| Activity # | Activity Description | Responsible Staff/Partners | Timeframe | Activity Status Update | Activity Status Summary |
|---|---|---|---|---|---|
| a | | | | | |
| b | | | | | |
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**Objective 2:**

| Activity # | Activity Description | Responsible Staff/Partners | Timeframe | Activity Status Update | Activity Status Summary |
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| a | | | | | |
| b | | | | | |
| c | | | | | |
| d | | | | | |

**Objective 3:**

| Activity # | Activity Description | Responsible Staff/Partners | Timeframe | Activity Status Update | Activity Status Summary |
|---|---|---|---|---|---|
| a | | | | | |
| b | | | | | |
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**APPENDIX E. PERFORMANCE MEASURE**

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| **Measure Area #1** | Birth Outcomes |
| **Measure Description** | Very Low Birth Weight |
| **Target Population** | Index Child |
| **Measure Specifications** | Percentage of index infants among women enrolled in home visiting program by 37 weeks gestational age who were born at very low birth weight |
| **Numerator** | Total number of live births classified as very low birth weight to mothers enrolled in the HVS pilot by 37 weeks gestational age |
| **Denominator** | Total number of live births to mothers enrolled in the HVS pilot by 37 weeks gestational age |

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| **Measure Area #2** | Child Health |
| **Measure Description** | Well Child Visits |
| **Target Population** | Index Child |
| **Measure Specifications** | Percentage of children who turned 15 months old during the measurement year and who had the following number of well-child visits with a primary care practitioner (PCP) during their first 15 months of life:<br>● No well-child visits<br>● One well-child visit<br>● Two well-child visits<br>● Three well-child visits<br>● Four well-child visits<br>● Five well-child visits<br>● Six or more well-child visits |
| **Numerator** | Seven separate numerators are calculated, corresponding to the number of children who received 0, 1, 2, 3, 4, 5, 6 or more well-child visits (Well-Care Value Set), on different dates of service, with a PCP during their first 15 months of life |
| **Denominator** | Total number of enrolled index children who turned 15 months old during the measurement year |

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| **Measure Area #3** | Maternal Health |
| **Measure Description** | Postpartum Visit |
| **Target Population** | Postpartum Women |
| **Measure Specifications** | The percentage of women who gave birth and had a postpartum visit on or between 21 and 56 days after delivery |
| **Numerator** | Number of unique women who had a postpartum visit on or between 21 and 56 days after delivery |
| **Denominator** | Total number of enrolled women who gave birth after being enrolled in the Home Visiting program |

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| **Measure Area #4** | Maternal Health |
| **Measure Description** | Postpartum Depression Screening |
| **Target Population** | Postpartum Women |
| **Measure Specifications** | Percentage of primary caregivers enrolled in home visiting who are screened for depression using a validated tool within 3 months of enrollment (for those not enrolled prenatally) or within 3 months of delivery (for those enrolled prenatally) |
| **Numerator** | For those not enrolled prenatally, number of primary caregivers enrolled in home visiting who are screened for depression within the first 3 months since enrollment; for those enrolled prenatally, the number of primary caregivers screened for depression within 3 months of delivery |
| **Denominator** | For those not enrolled prenatally, the number of primary caregivers enrolled in home visiting for at least 3 months; for those enrolled prenatally, the number of primary caregivers enrolled in home visiting for at least three months post delivery |

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| **Measure Area #5** | Maternal Health |
| **Measure Description** | Maternal Depression Receipt of Treatment for Maternal Depression |
| **Target Population** | Postpartum Women |
| **Measure Specifications** | Percentage of women who received a positive screen for depression and who then went on to receive services for depression |
| **Numerator** | Number of women who screen positive for depression who have followed through with a referral and received care for depression |
| **Denominator** | Number of women who have screened positive for depression using a validated depression screening tool and received a referral for treatment |

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| **Measure Area #6** | Child Health |
| **Measure Description** | Emergency Room Visits |
| **Target Population** | Index Child |
| **Measure Specifications** | Rate of All-Cause ER Visits among enrolled index children |
| **Numerator** | Number of index children who visit the ER and receive a Medicaid claimable services |
| **Denominator** | Total number of enrolled index children |

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| **Measure Area #7** | Child Health |
| **Measure Description** | Avoidable Emergency Room Visits |

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| **Target Population** | Index Child |
| **Measure Specifications** | Rate of Potentially Avoidable Emergency Room Visits among enrolled index children |
| **Numerator** | Number of index children who visit the ER and receive treatment for a Potentially Avoidable Emergency Room Visit |
| **Denominator** | Total number of enrolled index children |

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| **Measure Area #8** | Birth Outcomes |
| **Measure Description** | Preterm Birth |
| **Target Population** | Index Children |
| **Measure Specifications** | Percentage of infants (among mothers who enrolled in home visiting prenatally before 37 weeks) who are born preterm following program enrollment |
| **Numerator** | Number of live births (index child or subsequent children among mothers who enrolled in home visiting prenatally before 37 weeks) born before 37 completed weeks of gestation and after enrollment |
| **Denominator** | Number of live births after enrollment who were born to mothers enrolled in home visiting prenatally before 37 weeks |

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| **Measure Area #9** | Maternal Health |
| **Measure Description** | Tobacco Cessation |
| **Target Population** | Enrolled Caregiver/Mother |
| **Measure Specifications** | Percentage of primary caregivers enrolled in home visiting who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment |
| **Numerator** | Number of primary caregivers enrolled in home visiting who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment |
| **Denominator** | Number of primary caregivers enrolled in home visiting who reported using tobacco or cigarettes at enrollment and were enrolled for at least 3 months- |

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| **Measure Area #10** | Child Health |
| **Measure Description** | Lead Poisoning |
| **Target Population** | Index Child |
| **Measure Specifications** | Percentage of children enrolled in the program who have had a lead screening by the age of two |
| **Numerator** | Total number of enrolled index children who have received a blood lead level screening test by the age of two |
| **Denominator** | Total number of unique enrolled index children |

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| **Measure Area #11** | Child Health |
| **Measure Description** | Dental Care Utilization |
| **Target Population** | Index Child |
| **Measure Specifications** | Percentage of all enrolled index children who received at least one dental service within the reporting year |
| **Numerator** | Total number of unique enrolled index children who received at least one dental service within the reporting year |
| **Denominator** | Total number of unique enrolled index children |

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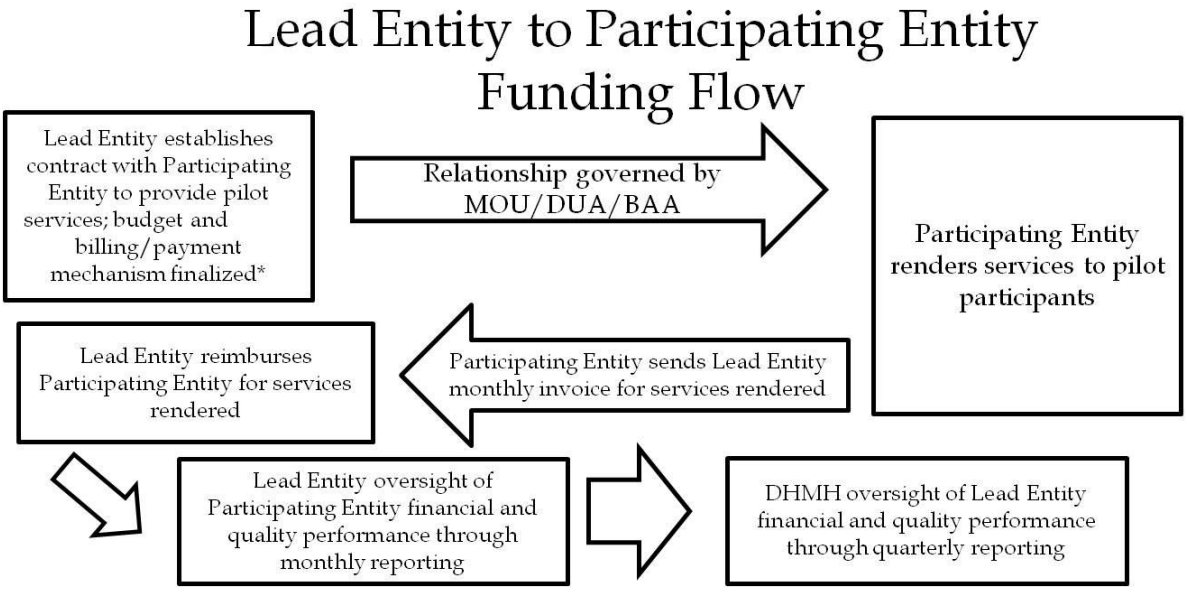
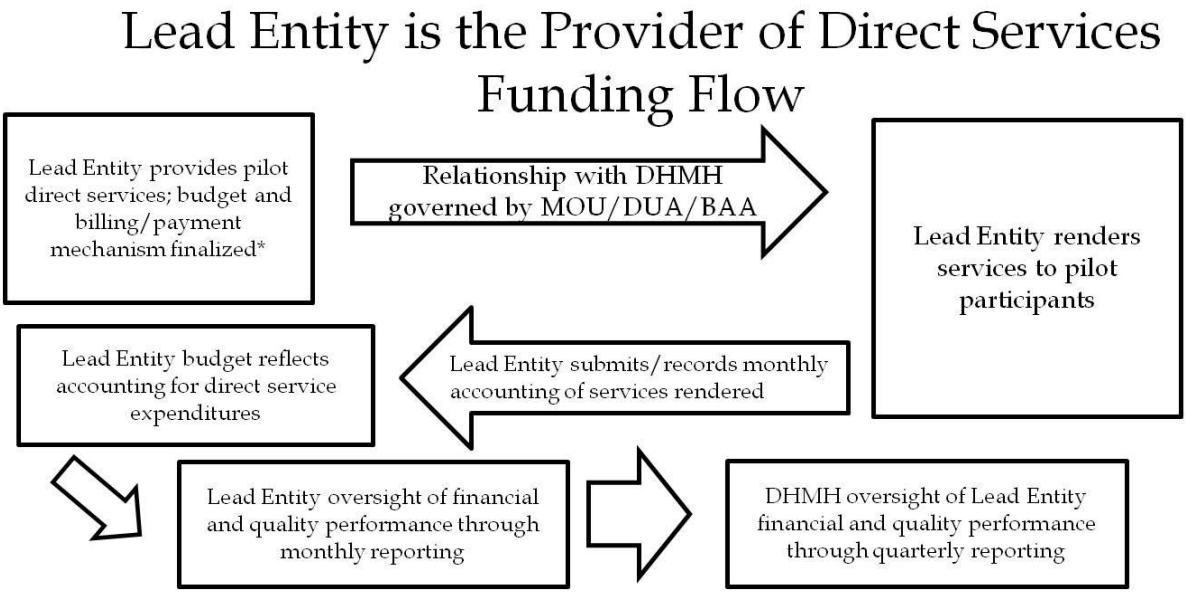
| **Measure Area #12** | Maternal Health |
| **Measure Description** | Postpartum Contraception |
| **Target Population** | Postpartum Women |
| **Measure Specifications** | Percentage of enrolled women ages 15-44 who adopted or had continued use of the most effective or moderately effective FDA-approved methods of contraception within 3 and 60 days of delivery |
| **Numerator** | Number of unique enrolled women ages 15-44 who adopted or had continued use of the most effective or moderately effective FDA-approved methods of contraception within 3 and 60 days of delivery |
| **Denominator** | Total number of unique enrolled postpartum women |

**APPENDIX F. SAMPLE FUNDING FLOW DIAGRAMS**



## APPENDIX G. ATTESTATIONS AND CERTIFICATION

### 6.1 Attestation

I certify that, as the representative of the HVS Pilot Lead Entity, I agree to the following conditions:

- The HVS Pilot Lead Entity will help develop and participate in routine HVS Pilot Entity status update calls with DHMH and other participants.

- The intergovernmental transfer (IGT) funds will qualify for federal financial participation per 42 CFR 433, subpart B, and will not be derived from impermissible sources, such as recycled Medicaid payments, federal money excluded from use as a state match, impermissible taxes, and non-bona fide provider-related donations. Sources of non-federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible intergovernmental transfers from providers, or federal funds received from federal programs other than Medicaid (unless expressly authorized by federal statute to be used for claiming purposes, and the federal Medicaid funding is credited to the other federal funding source). For this purpose, federal funds do not include PRIME payments, patient care revenue received as payment for services rendered under programs such as the Designated State Health Programs, Medicare, or Medicaid.

- Within 30 days of the determination of the quarterly payment due, DHMH will issue requests to the HVS Pilot for the necessary IGT amounts. The Lead Entity shall make IGT of funds to DHMH as per the final agreement between the Lead Entity and DHMH.

- Final approval of this application will be subject to the Lead Entity's mandatory agreement to the forthcoming Inter-Agency Agreement and Data Use Agreement, which will govern the exchange and utilization of the data involved in the HVS Pilot. Additionally, approval is contingent on CMS review and concurrence with the HVS Pilot's per visit rate request and underlying rate composite.

- The Lead Entity will report and submit timely and complete data to DHMH in a format specified by the state. Incomplete and/or non-timely data submissions may lead to a financial penalty after multiple occurrences and technical assistance is provided by the state.

- The Lead Entity shall submit quarterly and annual reports in a manner specified by DHMH. The HVS Pilot payments shall be contingent on whether progress toward the HVS Pilot requirements approved in this application has been made.

- The Lead Entity will meet with evaluators to assess the HVS Pilot.

- Federal funding received shall be returned if the HVS Pilot, or a component of it as determined by the state, is not subsequently implemented.

- Payments for HVS Pilots will be contingent on certain deliverables or achievements, and will not be distributed, or may be recouped, if Pilots fail to demonstrate achievement or

submission of deliverables.

- The Lead Entity will respond to general inquiries from the state pertaining to the HVS Pilot within one business day after acknowledging receipt, and provide requested information within five business days, unless an alternate timeline is approved or determined necessary by DHMH. DHMH will consider reasonable timelines that will be dependent on the type and severity of the information when making such requests.

- The Lead Entity understands that the state of Maryland must abide by all requirements outlined in the STCs and Post Approval Protocols. The state may suspend or terminate a Pilot if corrective action has been imposed and persistent poor performance continues. Should a HVS Pilot be terminated, the state shall provide notice to the HVS Pilot and request a close-out plan due to the state within 30 calendar days, unless significant harm to beneficiaries is occurring, in which case the state may request a close-out plan within 10 business days. All state requirements regarding Pilot termination can be found in the Post Approval Protocols.

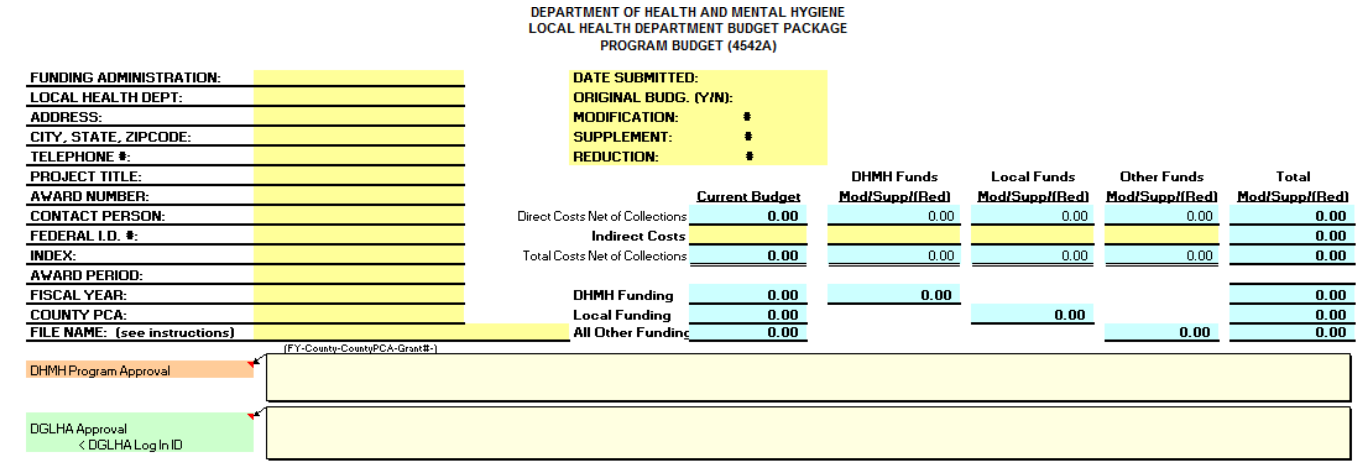
- The Lead Entity understands that this is a demonstration HVS Pilot to determine the efficacy of Medicaid financing for evidence based maternal and child health home visiting services and that changes to reporting requirements may occur or be expanded as necessary to support a successful HVS Pilot program evaluation. DHMH will try and minimize any changes and consult with HVS Pilot leadership in assessing any adjustments.

☐ I hereby certify that all information provided in this application is true and accurate to the best of my knowledge, and that this application has been completed based on a good faith understanding of HVS Pilot program participation requirements as specified in the Medicaid 1115 Waiver STCs, Attachment D: Pilot Protocol and the DHMH Frequently Asked Questions (FAQ) document.

| **Signature of Pilot Lead Entity Representative:** | **Date:** |
|---|---|
| | |

## APPENDIX H. BUDGET TEMPLATE (Form 4542a)

The image below is a screenshot of the Budget Template (Form 4542a). To download an editable Excel version of Budget Template (Form 4542a), please click on this link.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
LOCAL HEALTH DEPARTMENT BUDGET PACKAGE
PROGRAM BUDGET (4542A)

| | | | |
|---|---|---|---|
| FUNDING ADMINISTRATION: | | DATE SUBMITTED: | |
| LOCAL HEALTH DEPT: | | ORIGINAL BUDG. (Y/N): | |
| ADDRESS: | | MODIFICATION: | # |
| CITY, STATE, ZIPCODE: | | SUPPLEMENT: | # |
| TELEPHONE #: | | REDUCTION: | # |
| PROJECT TITLE: | | | |
| AWARD NUMBER: | | | |
| CONTACT PERSON: | | | |
| FEDERAL I.D. #: | | | |
| INDEX: | | | |
| AWARD PERIOD: | | | |
| FISCAL YEAR: | | | |
| COUNTY PCA: | | | |
| FILE NAME: (see instructions) | | | |

(FY-County-CountyPCA-Grant#-)

| | Current Budget | DHMH Funds Mod/Supp/(Red) | Local Funds Mod/Supp/(Red) | Other Funds Mod/Supp/(Red) | Total Mod/Supp/(Red) |
|---|---|---|---|---|---|
| Direct Costs Net of Collections | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Indirect Costs | | | | | 0.00 |
| Total Costs Net of Collections | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| DHMH Funding | 0.00 | 0.00 | | | 0.00 |
| Local Funding | 0.00 | | 0.00 | | 0.00 |
| All Other Funding | 0.00 | | | 0.00 | 0.00 |

DHMH Program Approval

DGLHA Approval
< DGLHA Log In ID

| | (1) LINE ITEM NO. | (2) LINE ITEM DESCRIPTION | (3) DHMH FUNDING REQUEST | (4) OTHER DIRECT FUNDING: LOCAL FUNDING | (5) OTHER DIRECT FUNDING: ALL OTHER FUNDING | (6) OTHER DIRECT FUNDING: TOTAL OTHER FUNDING (COL 4 + COL 5) | (7) TOTAL PROGRAM BUDGET (COL 3 + COL 6 + COL 11) | (8) DHMH BUDGET MOD., SUPP or REDUCTION CHANGES (+ OR -) | (9) LOCAL BUDGET MOD., SUPP or REDUCTION CHANGES (+ OR -) | (10) OTHER BUDGET MOD., SUPP or REDUCTION CHANGES (+ OR -) | (11) TOTAL OF MODIFICATIONS, SUPPLEMENTS OR REDUCTIONS (Col 8 + Col 9+ Col 10) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 0111 | Salaries | | | | 0 | 0 | | | | 0 |
| 2 | 0121 | FICA | | | | 0 | 0 | | | | 0 |
| 3 | 0131 | Retirement | | | | 0 | 0 | | | | 0 |
| 4 | 0139 | Def Compensation | | | | 0 | 0 | | | | 0 |
| 5 | 0141 | Health Insurance | | | | 0 | 0 | | | | 0 |
| 6 | 0142 | Retiree Health Insurance | | | | 0 | 0 | | | | 0 |
| 7 | 0161 | Unemployment Insurance | | | | 0 | 0 | | | | 0 |
| 8 | 0162 | Workmen's Compensation | | | | 0 | 0 | | | | 0 |
| 9 | 0171 | Overtime Earnings | | | | 0 | 0 | | | | 0 |
| 10 | 0181 | Additional Assistance | | | | 0 | 0 | | | | 0 |
| 11 | 0182 | Adjustments | | | | 0 | 0 | | | | 0 |
| 12 | 0201 | Consultants | | | | 0 | 0 | | | | 0 |
| 13 | 0280 | Special Payments Payroll | | | | 0 | 0 | | | | 0 |
| 14 | 0291 | FICA | | | | 0 | 0 | | | | 0 |
| 15 | 0292 | Unemployment Insurance | | | | 0 | 0 | | | | 0 |
| 16 | 0299 | Contractual Services - Salaries & Fringe | | | | 0 | 0 | | | | 0 |
| 17 | 0301 | Postage | | | | 0 | 0 | | | | 0 |
| 18 | 0305 | Telephone | | | | 0 | 0 | | | | 0 |
| 19 | 0405 | In-state Travel | | | | 0 | 0 | | | | 0 |
| 20 | 0409 | Out-of-State Travel | | | | 0 | 0 | | | | 0 |